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Good afternoon, Mr. Chairman and Members of the Subcommittee. Thank you for inviting me before you today. It is a pleasure and honor for me to have the opportunity to update you on the U.S. Department of Health and Human Services' (HHS or the Department) improper payment initiatives.

The Department is firmly committed to ensuring the highest measure of accountability to the American people. With the size and scope of HHS programs, we know that it is critical to prioritize and be aggressive in our activities to identify and take action to reduce improper payments. Over the past several years, we have had many successes and accomplishments in this area. I am pleased to share some of these with you today as well as some of the challenges we face.

As required under the Improper Payments Information Act of 2002 (IPIA) and related guidance issued by the Office of Management and Budget (OMB), the Department is estimating, or in the process of developing or implementing methodologies to estimate improper payments for seven of its programs: Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), Temporary Assistance for Needy Families (TANF), Foster Care, Head Start and the Child Care and Development Fund (CCDF). These seven programs account for close to 90 percent of HHS' $640 billion total estimated FY 2006 outlays. In terms of both size and potential for growth, the risk and impact of improper payments is greatest for the two HHS programs which account for 80 percent of the total outlays – Medicare and Medicaid. I will describe briefly the activities and initiatives HHS is engaging in for each of these programs. It is important to note that my testimony today

is primarily focused on improper payments. Those cases involving fraud are referred to the HHS Office of the Inspector General (OIG) and prosecuted by the Department of Justice (DOJ), which provides an important deterrent to fraudulent payment schemes.

MEDICARE

The Department's largest program, Medicare, accounts for close to 50 percent of the HHS outlays. Medicare is a Federal health insurance program administered by HHS that provides medical insurance to 42 million people. The majority of Medicare spending is for fee-for-service (FFS) hospital and physician services. The FFS component of Medicare covers a wide range of other items and services, including home health care, ambulance services, medical equipment, and preventive services. The HHS Centers for Medicare & Medicaid Services (CMS) administers the Medicare FFS claims processing and payment systems through contracts with Carriers, Durable Medical Equipment Medicare Administrative Contractors, and Fiscal Intermediaries (FIs). These entities, in addition to Quality Improvement Organizations (QIOs) and Payment Safeguard Contractors (PSCs), review claims submitted by other providers to ensure payments are made only for medically necessary services covered by Medicare for eligible individuals. HHS estimates that the contractors processed over one billion claims from providers, physicians, and suppliers for items and services that Medicare covers.

In 1996, HHS' OIG began estimating improper payments in the Medicare FFS program as part of the financial statement audit required by the Chief Financial Officer's Act of 1990. The OIG produced FFS error rates from FYs 1996 - 2002. Beginning in FY 2003,

HHS, working with the OIG, implemented a more robust process – the Comprehensive Error Rate Testing (CERT) program – to assess and measure improper payments in the Medicare FFS program. The CERT program not only produces a national paid claims error rate but also provides very specific improper payment rates, including contractor-specific improper payment rates which measure the accuracy of our claims processors; provider-type specific improper payment rates which measure how well the providers who care for beneficiaries are preparing and submitting claims; and benefit service-type improper payment rates and other management related information which provides insight into payment errors by region and reason. The Medicare FFS improper payment estimate is derived from two programs; the CERT program and the Hospital Payment Monitoring Program (HPMP). Each component represents about 50 percent of the total FFS Medicare payments. The CERT program has provided HHS with a powerful tool to identify problems in claims processing and address these problems through specific corrective action plans.

In November 2005, HHS reported a Medicare FFS paid claims error rate of 5.2 percent, which is significantly lower than the 10.1 percent rate reported in FY 2004. Our goal was to lower the national Medicare FFS error rate to 7.9 percent by November of 2005, with a long term goal of 4.7 percent by 2008. We have far exceeded our goal in having reduced the error rate 2.7 percent beyond the 2005 target.

The significant reduction in the Medicare FFS error rate from 2004 to 2005 can be attributed to marked improvement in the no documentation and the insufficient documentation error rates. In the past, a primary cause of Medicare payment errors has

been providers not submitting the medical record documentation needed to verify the appropriateness of payment in response to our requests for documentation. Often providers did not understand the CERT program or were concerned that submitting medical records to a HHS contractor would be in violation of Health Insurance Portability and Accountability Act (HIPAA) regulations. However, the HIPAA Privacy Rule permits disclosure of protected health information to carry out treatment, payment or health care operations. Thus we expanded our education efforts to ensure that providers understand that responding to our requests does not violate HIPAA. Documentation is crucial to the medical review process used to verify the appropriateness of payment. If the documentation is missing or incomplete, no determination can be made. Historically, the CERT program has taken a conservative approach to dealing with missing or insufficient medical record documentation; a claim with missing or incomplete documentation was scored as an error.

Another significant cause of errors has been providers not submitting the appropriate types of medical record documentation to support the types of services billed to the Medicare program. HHS took action to help reduce these errors by giving providers an opportunity to submit additional documentation if the initial review of the medical records indicated that the provider's first submission was insufficient to make a determination.

These aggressive actions successfully lowered the number of no documentation and insufficient documentation errors: the no documentation rate was reduced from 3.1

percent of the error rate in 2004 to .7 percent in 2005. The insufficient documentation error rate dropped from 4.1 percent in 2004 to 1.1 percent in 2005.

Beginning this year, HHS will be producing error rates twice a year. This increased availability of data will help HHS and its contractors to better target efforts to reduce error rates.

The CERT and HPMP statistical methodologies that HHS uses to calculate the Medicare national FFS error rate were reviewed by PricewaterhouseCoopers, LLP (PwC) in FY 2004. As a result of the review, PwC reported the "fee-for-service error rate to be statistically valid." In addition, GAO issued a report this past month entitled "CMS Methodology Adequate to estimate National Error Rate," which supports the adequacy of the methodology.

While the CERT program and HPMP have been useful for guiding our efforts in the Medicare FFS program, they do not provide a measure for payments in Medicare Advantage or the Medicare Prescription Drug Benefit Program. These programs added by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) represent about 18% of Medicare benefit outlays in FY 2006, and will grow in future years. HHS is in the process of evaluating how to best address improper payments in these programs.

HHS program integrity activities are primarily funded through the Medicare Integrity Program (MIP), established by the HIPAA. The MIP includes medical review and benefit integrity activities, provider education and training, Medicare Secondary Payer, and provider audits. HHS overall program integrity efforts are supplemented by funding from HHS program management account and other funds made available from the Health Care Fraud and Abuse Control (HCFAC) account. Additionally, new Medicare contractor reform legislation enacted through the MMA and the implementation of the new Healthcare Integrated General Ledger Accounting System, will further enhance MIP's effectiveness.

When Congress enacted the Deficit Reduction Act of 2005 (DRA), they included additional one-year funding for MIP in FY 2006 to help fund program integrity efforts in the new MMA Medicare Advantage and prescription drug benefit programs. DRA also included additional funding in FY 2006 and beyond for the Medicare-Medicaid data match (Medi-Medi) program in MIP.

The Administration's budget request for FY 2007 provides new resources for reducing improper payments. The budget includes $1.1 billion from the HCFAC account to fight improper Medicare and Medicaid payments and other health care fraud, waste, and abuse. To supplement these efforts, the Budget requests $118 million for efforts to protect the new Medicare prescription drug benefit and the MA program against fraud, waste, and error, as well as reduce errors in Medicaid. These funds are part of a

Government-wide proposal to fund program integrity activities through a discretionary cap adjustment.

HHS' actions to safeguard Federal funds are not just limited to the error rate programs described in this testimony. Program and fiscal integrity oversight is an integral part of the HHS financial management strategy and a high priority is placed on detecting and preventing improper or fraudulent payments. To that end, HHS has made significant changes to its program integrity activities in the past year. These changes include the creation of new divisions within HHS to focus on data analysis to identify problem areas through trend analysis of claims data and to oversee potential fraud areas in the discount drug card and prescription drug benefit programs.

Several specific actions have been taken by HHS to ensure that Federal dollars are being properly spent and fraudulent billings are stopped when they are detected. In particular, a satellite office in Los Angeles, California has been created to work in conjunction with an existing satellite office in Miami, Florida and has been instrumental in helping curtail fraudulent spending in high risk areas. Nine Medi-Medi projects that HHS has in place in key States also help identify aberrant spending through their matching of Medicare and Medicaid claims data. For the first time, Medicare claims and Medicaid claims are being jointly data mined to identify fraud and abuse. Data mining health care claims for fraudulent activity has been commonplace for several years now. However, by blending both programs' claims, patterns emerge that may not have been as evident when viewed separately. In many cases, a small number of fraudulent providers are exploiting both

programs. The knowledge gleaned from our Medi-Medi activities helps both programs identify vulnerabilities and plug those gaps. This project will help reduce overall payment errors. Since inception, the Medi-Medi projects have yielded 335 investigations with an estimated $182 million dollars at risk.

When instances of fraud or abuse are detected through any of these oversight mechanisms, HHS refers those cases to law enforcement. HHS has actively partnered with its law enforcement partners at the DOJ and OIG to aggressively pursue enforcement actions against those providers and suppliers that are found to be deliberately defrauding the Federal health care programs.

MEDICAID AND STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)

The Department's second largest program, Medicaid, accounts for over 30 percent of Department outlays. Unlike Medicare, it is administered primarily by State Governments. While the Federal Government provides financial matching payments to the States, each State is responsible for overseeing its Medicaid Program, and each State essentially designs and runs its own program within the Federal structure. The Federal Government pays the States a portion of their costs through a statutorily determined matching rate called the Federal Medical Assistance Percentage, or FMAP, that currently ranges between 50 and 76 percent. In FY 2006, total Medicaid expenditures – those that include both Federal and State contributions – are estimated to be approximately $340 billion.

In FY 2000, HHS adopted a Government Performance and Results Act (GPRA) goal to explore the feasibility of developing a methodology to estimate improper payments in the Medicaid Program. Beginning in 2001, HHS formally solicited States to participate in the development of a model to estimate payment accuracy. Only three States, Illinois, Texas, and Kansas, had attempted to estimate payment error in their respective State Medicaid Programs prior to HHS initiating pilot projects.

From FYs 2002-2005, HHS conducted the Payment Accuracy Measurement (PAM) and Payment Error Rate Measurement (PERM) pilot projects with extensive collaboration from participating States to determine a systematic means of measuring payment errors at the State and national levels. From these pilot projects, HHS was able to develop a methodology to estimate a State-specific payment error rate that would be the basis for the national Medicaid error rate as well as the SCHIP.

In FY 2006, contractors will measure a national Medicaid FFS error rate in 17 States based on medical reviews and data processing reviews. In FYs 2007 and 2008, contractors will measure national Medicaid and SCHIP FFS and managed care (MC) payments in 17 selected States, and the States will measure eligibility payment errors. Comprehensive Medicaid and SCHIP error rates (MC, FFS and eligibility) will be reported in the FY 2008 PAR.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)

The TANF Program provides a capped pre-appropriated annual block grant of approximately $16.5 billion to States, Territories and eligible Tribal programs to help families transition from welfare to self-sufficiency. In the past several years, HHS has worked toward identifying strategies for estimating payment errors in the TANF Program. Four different activities were identified to assist in efforts to reduce the occurrence of improper payments in the TANF Program. These activities and related actions taken include:

- HHS is soliciting information from States on their practices for identifying and reducing improper payments in the TANF Program. HHS developed a survey instrument to solicit information on State systems and practices for identifying and reducing improper payments in the TANF Program that will be placed on a website for information sharing among the States;

- HHS conducted an improper payments pilot project with volunteer States in which the States had a more in-depth review of TANF expenditures during their OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations,* audit process. The objective of the pilot is to explore the viability of estimating improper payments using the A-133 audit process. HHS obtained agreement from one State (Alabama) to participate in the A-133 audit pilot project. In the expanded audit, the auditors used a statistical sample of a fixed size for a test of controls (attribute sampling method). The auditors reviewed 208

TANF cases to achieve a 95 percent confidence level with an expected deviation rate of 2.25 percent. The auditors reported an overall case error rate of 20 percent and a payment error rate of 3.9 percent. HHS contacted six States to increase the number of States participating in the A-133 pilot in FY 2006. Of the six States contacted, only three States agreed to participate. HHS will report on the results of the audits in these three States in the FY 2006 PAR;

- HHS initiated various activities to improve data match capability and increase State utilization of the Public Assistance Reporting Information System (PARIS). PARIS provides a Federal computer matching capability to assist State Public Assistance Agency (SPAA) efforts to validate client-reported information and identify potential improper payments (using client social security numbers) in the Medicaid, TANF and Food Stamps Programs. PARIS includes the Department of Veterans Affairs (VA) match and a VA spousal match; a Department of Defense/Office of Personnel Management match (active and retired military personnel and Federal employees); and an interstate match (duplicate payments made to the same client in more than one State). Every quarter, PARIS member States voluntarily choose whether, and in which match to participate (at no charge to them). The more States that join and conduct matches under PARIS, the wider the net of potential matches of information becomes available to PARIS member States to validate public assistance program client-reported information and identify potential improper payments – especially under the interstate match. HHS also engaged in a number of activities to improve data match capability and

usefulness, as well as increasing State utilization of PARIS. HHS will continue to work on expanding State participation and improving PARIS capability in FY 2006; and

- HHS is continuing to expand State access to the National Directory of New Hires (NDNH). The NDNH offers solutions to the prevalent under-detection by States and reporting of employment of TANF recipients. The NDNH was authorized under the welfare reform legislation to provide a national database of employment information for the purpose of collecting child support payments. The NDNH contains three database components: 1) new hires – information on new employees (filled out W-4 data); 2) quarterly wage data which includes information on individual employees from the records of State workforce and Federal agencies; and 3) unemployment compensation. HHS has initiated a demonstration project to provide State TANF agencies direct access to match their TANF caseloads against the databases. This effort began with a pilot effort in the District of Columbia (DC). In the DC pilot, 33 percent of the individuals submitted were matched to a possible job, and over 81 percent of those identified were verified as actually being employed. Of those verified as employed, DC closed 47 percent of the cases and reduced benefits for 53 percent of the cases. The vast majority of these recipients were not known to be employed by the State TANF agency. In FY 2005, all State TANF agencies were given access to the NDNH. To encourage use of the NDNH to carry out program responsibilities, HHS has provided States access to conduct up to 12 matches (one per month)

against the New Hires (W-4 data) database in FY 2006. Since July 2005, 31 States, DC and Puerto Rico have conducted matches. Together, these States and Territories account for 82 percent of the TANF caseload. During FY 2006, HHS will continue working with the States.

Although HHS is engaging in many activities which have been quite successful in identifying improper payments, HHS has not yet identified an efficient and effective approach for determining an estimate of improper payments in the TANF Program. One of our most significant challenges has been the flexibility that States have in the design and administration of the program. Also, there are statutory limitations with regard to the information that HHS can request of States. HHS is in the process of considering the work that has been done thus far and will be exploring other potential approaches in the coming months toward formulating a feasible and detailed plan for estimating payment errors in TANF.

HEAD START

The Head Start Program is an $6.8 billion program that provides grants to local public and non-profit agencies to provide comprehensive child development services to children and families, primarily preschoolers from low-income families. Head Start regulations allow Head Start programs to serve up to 10 percent of their enrolled children (49 percent in certain situations for tribal Head Start programs) from families who do not meet Head Start income requirements. Under Head Start legislation, grantees are required to be monitored at least once every three years. In FY 2004, HHS developed a methodology for

estimating a national Head Start payment error rate building on the required review process. HHS has reported Head Start payment error rates in FY 2004 (3.9 percent) and FY 2005 (1.6 percent).

FOSTER CARE

The Foster Care Program is a $4.8 billion program that is designed to help States provide safe, appropriate, 24-hour, substitute care for children who are under the jurisdiction of the administering State agency and who need temporary placement and care outside their homes. Under the regulatory review promulgated at 45 CFR 1356.71, primary reviews are conducted in each State every three years by teams who review 80 cases selected from the State's title IV-E foster care population. These reviews are intended to recover title IV-E funds claimed by States for ineligible cases and, in conjunction with the required program improvement plan (PIP) for those States determined to be non-compliant, to help change their behavior so that subsequent reviews will result in lower error rates.

HHS developed a methodology for estimating a national payment error rate for the title IV-E Foster Care Program using data gathered in the eligibility reviews conducted in FY 2001 - 2004. The FY 2004 error rate was 10.33 percent and the FY 2005 final error rate was 8.6 percent.

HHS has begun measuring underpayments in the reviews that are being conducted in FY 2006. In the coming year, HHS will continue to measure error cases and begin implementing its plan to measure Foster Care administrative cost payment errors.

CCDF

The Child Care and Development Fund (CCDF), a $4.9 billion block grant program, is composed of three distinct funding elements (mandatory, discretionary and matching) authorized in two different statutes. During FY 2003, HHS began to work toward identifying strategies for estimating payment errors in CCDF. In FY 2004, HHS initiated an improper payment pilot project to assess the efforts of eleven States to prevent and reduce improper payments in their child care programs and to explore feasible strategies to measure and estimate improper payments for the program. HHS expanded State participation in the pilot project from eleven to eighteen States in FY 2005 and continued to work on a strategy for determining a payment error rate in the CCDF. Further, HHS partnered with Regional and State staff to test an error rate methodology in four States focused on the client eligibility process.

HHS drafted a report of the findings which includes a preliminary error rate calculated for each of the four States and an estimated analysis of the cost incurred by each State. HHS also developed a survey instrument to solicit information on a voluntary basis from States on State systems and practices for identifying and reducing improper payments in the CCDF.

CCDF gives the States flexibility in the design and administration of the Program which has presented challenges in developing a model or methodology that can be used by all States. HHS is developing a plan for applying the error rate methodology that was tested in the four States in FY 2005, to all the States over time. This methodology focuses on client eligibility and involves an intensive case review process to identify cases with errors, cases with improper payments, percentages of payments made in error, average amounts of improper payments, and minimum and maximum amounts of improper payments. It is expected that by the end of FY 2007, HHS will have error rates for nine States.

CONCLUSION

Mr. Chairman, and Subcommittee members, in conclusion, HHS has had numerous accomplishments and successes in its improper payment activities. In our largest program, Medicare, we are estimating improper payments and seeing the results of our corrective actions in a significant drop in the error rate. In our second largest program, Medicaid, we have developed and are working on implementing a plan for estimating improper payments. In two other programs, Head Start and Foster Care, we have achieved efficiencies in utilizing reviews required by legislation or regulation in developing our methodologies for determining estimates in these programs. In Medicare, Head Start and Foster Care Programs we experienced a decrease in improper payments through identification and implementation of appropriate corrective action. In the CCDF Program, we will begin implementing an approach for estimating payment errors in the near future. In the coming months, HHS plans to consider the results of TANF activities,

perform various analyses, and explore the viability of other strategies recently identified for estimating TANF improper payments. Our data matches and pilot activities have not only been successful in identifying and reducing improper payments, they have allowed us to build strong partnerships with the States in our endeavors to reduce improper payments. In the coming months, we will continue to work toward achieving compliance with the IPIA in overcoming the challenges we face in our TANF program and in implementing our plans for estimating improper payments in the Medicaid, SCHIP and CCDF Programs.

Thank you again for this opportunity to talk update you on the Department's improper payment initiatives. At this time, I will be pleased to answer any questions.